DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445017	A. BUILDING _____ B. WING _____	01/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASBURY PLACE AT MARYVILLE	2648 SEVIERVILLE RD MARYVILLE, TN 37804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An annual Recertification survey and complaint investigation #'s 30939, 30986, 30879, and 30896, were completed on January 10, 2013, at Asbury Place at Maryville. No deficiencies were cited related to the complaint investigations under 42 CFR Part 483, Requirements for Long Term Care Facilities.	F 000		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding	F 272	F – 272 –Resident #191 was placed on the Incontinence Monitoring Record to assess voiding pattern on 1/31/2013. The Bladder Incontinence Assessment will be completed by 2/7/13 and will be placed on the appropriate toileting plan based on this assessment. Other residents having the potential to be affected will be identified by performing an Incontinence Monitoring Record upon admission and will receive a Bladder Incontinence Assessment by a licensed nurse. Based on the assessment, the resident will be placed into the appropriate toileting plan per the facility Bowel and Bladder Program. All residents residing in facility based on census of 1/31/2013 will have their chart audited for a completed bladder assessment. These assessments will be updated by 3/15/2013.	2/24/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Tega L. Brown | TITLE: Executive Director | (X6) DATE: 2-18-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 272	Continued From page 1 the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to assess the bladder continence needs for one resident (#191) of thirty-nine residents reviewed. The findings included: Resident #191 was admitted to the facility on August 1, 2012, with diagnoses including Altered Mental Status, Chronic Airway Obstruction, Hypertension, Gastroesophageal Reflux Disease, and Anxiety. Medical record review of the admission minimum data set (MDS) dated August 13, 2012, revealed the resident required supervision with set-up help only for bed mobility, transfers, and walking in room. Continued review of the same MDS revealed the resident required extensive assistance of one person for dressing, toilet use, personal hygiene and was "...frequently incontinent of bladder and bowel..." Medical record review of the quarterly MDS dated	F 272	The Staff Development Coordinator will in service all nursing staff on the Bowel and Bladder Program by 2/20/13. The DON and RN Supervisors will conduct audits on these assessment for completion and appropriate toileting plan. These measures will be audited for 10 residents per week for 4 weeks, then 10 residents per month for 3 months. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	

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F 272	Continued From page 2 November 11, 2012, revealed the resident was "always incontinent of bladder and bowel," indicating a decline from the admission MDS. Review of the facility's Incontinence Monitoring Record dated August 2 through August 8, 2012, revealed the resident's voiding pattern (toileting habits) had been monitored for seven days. Continued review of the Incontinence Monitoring Record revealed the resident's voiding pattern had been categorized as voided, wet, and dry. Review of the Bladder Incontinence Assessment dated August 8, 2012, revealed the document was blank. Review of facility policy, Instructions for Patterning Tool, revealed, "1. Select residents first who have the greatest chance of going from incontinence to continence. 2. Begin patterning at midnight; check on resident every hour and enter a "x" in the appropriate box. 3. Once patterning is complete; notify nurse so she/he can complete the nursing assessment ..." Interview in the conference room on January 10, 2013, with the Unit Manager of the secured unit on January 10, 2013, at 2:30 p.m., confirmed the bladder assessment had not been completed for the resident as per the facility's policy.	F 272		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident	F 315	F-315 - Resident #191 was placed on the Incontinence Monitoring Record to assess voiding pattern on 1/31/2013. The Bladder Incontinence Assessment will be completed by 2/7/13 and will be placed on the appropriate toileting plan based on this assessment.	3/15/13

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F 315	Continued From page 3 who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview, the facility failed to ensure treatment and services were provided to prevent decline in bladder continence for one resident (#191) of thirty-nine residents reviewed. The findings included: Resident #191 was admitted to the facility on August 1, 2012, with diagnoses including Altered Mental Status, Chronic Airway Obstruction, Hypertension, Gastroesophageal Reflux Disease, and Anxiety. Medical record review of the admission Minimum Data Set (MDS) dated August 13, 2012, revealed the resident required supervision with set-up help only for bed mobility, transfers, and walking in room. Continued review of the same MDS revealed the resident required extensive assistance of one person for dressing, toilet use, personal hygiene, and was "frequently incontinent of bladder and bowel." Medical record review of the quarterly MDS dated November 11, 2012, revealed the resident was "always incontinent of bladder and bowel," indicating a decline from the admission MDS.	F 315	Other residents having the potential to be affected will be identified by performing an Incontinence Monitoring Record upon admission and will receive a Bladder Incontinence Assessment by a licensed nurse. Based on the assessment, the resident will be placed into the appropriate toileting plan per the facility Bowel / and Bladder Program. All residents residing in facility based on census of 1/31/2013 will have their chart audited for a completed bladder assessment. These assessments will be updated by 3/15/2013. The Staff Development Coordinator will in service all nursing staff on the Bowel and Bladder Program by 2/20/13. The DON and RN Supervisors will conduct audits on these assessment for completion and appropriate toileting plan. These measures will be audited for 10 residents per week for 4 weeks, then 10 residents per month for 3 months.	

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F 315	Continued From page 4 Review of the facility's Incontinence Monitoring Record dated August 2 through August 8, 2012, revealed the resident's voiding pattern (toileting habits) had been monitored for seven days. Continued review of the monitoring record revealed the resident's voiding pattern had been categorized as voided, wet, and dry. Review of the Bladder Incontinence Assessment dated August 8, 2012, revealed the document was blank. Review of facility policy, Instructions for Patterning Tool, revealed, "1. Select residents first who have the greatest chance of going from incontinence to continence. 2. Begin patterning at midnight; check on resident every hour and enter a "x" in the appropriate box. 3. Once patterning is complete; notify nurse so she/he can complete the nursing assessment ..." Interview with the Unit Manager of the secured unit in the conference room on January 10, 2013, at 2:30 p.m., confirmed the facility had failed to provide treatment and services to address the resident's decline in bladder continence.	F 315	The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS; Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	
F 333 SS=G	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on medical record review, review of a facility investigation, facility policy review, and interview, the facility failed to ensure residents were free of significant medication errors for one	F 333	F 333 – The Medical Director was notified immediately of the medication error. Resident # 124 received immediate emergency treatment per Medical Director's orders and was transported to hospital for further treatment. Disciplinary actions were given for the nurse making the medication error and the nurse preceptor.	2/24/13

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F 333	Continued From page 5 resident (#124) of thirty-nine residents reviewed. The medication error resulted in an emergent hospitalization and harm for resident #124. The findings included: Resident #124 was admitted to the facility on September 24, 2012, with diagnoses including History of Falls, Postoperative Repair of Femur Fracture, Osteoporosis and Alzheimer's Dementia. Medical record review of the quarterly Minimum Data Set (MDS) dated December 24, 2012, revealed the resident was severely cognitively impaired and required extensive staff assistance for all activities of daily living. Medical record review of a Physician's Progress Note dated January 4, 2013, revealed the resident had been administered the following medications prescribed for the resident's roommate: Hydralazine 100 milligrams (mg) (antihypertensive medication), Levemir 5 units (insulin/diabetic medication), Keppra 500 mg (anticonvulsant), Tylenol, Aspirin, Ferrous Sulfate, Carvedilol 25 mg (antihypertensive), Citalopram 20 mg (antidepressant), and Diltiazem 60 mg (cardiac medication/lowers blood pressure and heart rate). Continued review of the Physician's Progress Note dated January 4, 2013, revealed the medication error resulted in a sharp decrease in blood pressure (72/40) and heart rate (48) for the resident, and required emergent transport to the local hospital, and a three day admission to the intensive care unit. The resident was returned to the facility by ambulance on January 7, 2013.	F 333	Assessment was completed house wide for all residents to check for proper identification including armbands and photo identification on resident MAR. Armbands were placed / updated (replaced) for any residents who did not have a current armband. Photos were taken and placed on the MAR for any resident needing an updated photo. The Administrator, DON and Staff Development Coordinator conducted in-services for all nursing staff on the Medication Administration policy. This in-service covered topics including proper identification of residents prior to administering medications and the five rights of medication administration. The nursing orientation policy was reviewed and revised. The DON and Staff Development Coordinator in serviced all nursing staff on the revised policy. This included training on supervision of new nurses during the orientation period.	

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ASBURY PLACE AT MARYVILLE	2849 SEVIERVILLE RD MARYVILLE, TN 37804

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F 333	Continued From page 6 Review of an undated facility policy, Medication Administration, revealed "...before giving a resident any medication: validate the medication: right resident, right medication, right dose, right route, right time...identify the resident by using one of the following: photo identification, resident's identification bracelet, or have the resident state their name...no medication will be given if the resident cannot be identified..." Review of a facility investigation dated January 4, 2013, revealed a Medication Error Report which stated "...Description of error: resident rec'd (received) ASA 81 mg (aspirin), Coreg 25 mg, Celexa 20 mg, Diltiazem 60 mg, Hydralazine 100 mg, Keppra 500 mg, MPAP 500 mg...nurses will be more careful to identify correct resident...pictures of residents put (with) MAR (Medication Administration Record) and ID (identification) bracelets applied to each resident..." The facility investigation included a statement by the Director of Nursing (DON), who responded at the time of the medication error. The DON assisted the LPNs in attempts to stabilize the resident's blood pressure with IV (intravenous) fluids, and obtained physician's orders for the resident to be transported to the hospital, as the resident's blood pressure continued to drop. Interview with Licensed Practical Nurse (LPN #2) on January 10, 2013, at 10:25 a.m., in the third floor nurse's station, confirmed on January 4, 2013, during the morning medication pass, the facility policy regarding medication administration and resident identification had not been followed. Continued interview confirmed a medication error	F 333	The DON and RN Supervisors will conduct random medication administration audits on 10 residents per week for 4 weeks, then 10 residents per month for 3 months to check for proper resident identification and proper adherence to the Medication Administration Policy including the five rights of medication administration. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	

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ASBURY PLACE AT MARYVILLE	2548 SEVIERVILLE RD MARYVILLE, TN 37804

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F 333	Continued From page 7 occurred when resident #124 received the roommate's medications (listed above). The LPN provided a signed statement, to the DON, as a part of the facility investigation into the medication error. The LPN's signed statement revealed a new nurse/orientee had administered the medications, in the third floor dining area, without correctly identifying the two residents. The error was discovered and reported when the roommate's family member, familiar with both residents, recognized resident #124 had received an insulin injection prescribed for the roommate. During the interview LPN #2 confirmed the signed statement was complete regarding the details of the incident. Interview with the DON and Administrator on January 10, 2013, at 2:00 p.m., in the Administator's office, confirmed on January 4, 2013, the facility policy related to medication administration and resident identification had not been followed, and a medication error occurred. This medication error resulted in harm and hospitalization for the resident.	F 333		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	F 441 – C.N.A. #1 was re-educated by the RN on infection control including not blowing on resident food while feeding. The Staff Development Coordinator will in-service all nursing staff on infection control procedures while feeding a resident.	2/24/13

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F 441	Continued From page 8 (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to prevent/minimize the transmission of potential airborne contamination for one resident during a random observation at mealtime. The findings included: Observation of the secured unit dining room on January 7, 2013, at 12:40 p.m., of Certified Nurse Assistant (CNA) #1 assisting the resident with	F 441	The DON and RN Supervisors will conduct random direct observation audits on 10 residents per week for 4 weeks, then 10 residents per month for 3 months during meal times to ensure proper infection control procedures are followed. The results of the audits will be reviewed at the Quality Assurance Committee (DON, Administrator, Facilities Director maintenance and housekeeping, MDS, Pharmacy, Social Services, Medical Director, ADON, Dining Services) meeting, beginning in February, monthly for three (3) months and recommendations implemented, as appropriate.	

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F 441	Continued From page 9 eating revealed the CNA scooped the food onto a spoon from the resident's plate, held the spoon close to the CNA's mouth, blew on the food, and offered the food to the resident to consume. Continued observation revealed the resident opened the mouth and easily accepted the food. Continued observation revealed the process was repeated four times during the observation. Interview with CNA #1 on January 7, 2013, at 1:30 p.m., confirmed blowing on the resident's food to ensure a safe temperature was not an acceptable method of testing the food temperature. Interview with the Unit Manager on January 7, 2013, at 1:35 p.m., in the Unit Manager's office confirmed blowing on the resident's food was not an acceptable means of infection control.	F 441		